Washington State Department of Health

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|---|---|---|
| Date Received: | Priority Order: | |
| Application #: | Waiver #: | |
| Reviewed By: | | |

## APPLICATION FOR J-1 VISA WAIVER PROGRAM

| | |
|---|---|
| **US DEPARTMENT OF STATE CASE NUMBER** (This number must be obtained prior to submitting application) | ☐ Specialist Application (As defined by WAC 246-562-080 (4))<br>☐ Primary Care Application |

Please Type or Print Clearly, Read all instructions carefully. Complete all sections of this application and attach all required documentation. Incomplete applications will be returned. Please refer to WAC Chapter 246-562 for additional information. It is suggested that the physician works with an immigration attorney to assemble the documents required in this application and to ensure all other steps are in place that will allow the physician to live and work in the United States.

All documentation must have the Department of State Case Number on the bottom right hand corner of each page. If you have questions concerning the completion of this application, please contact the Washington State Department of Health's (DOH) Office of Community and Rural Health at the following website. http://www.doh.wa.gov/hsqa/ocrh

## DATA SHEET

| | | | |
|---|---|---|---|
| APPLICANT (HEALTH CARE FACILITY) | | | |
| APPLICANT BUSINESS MAILING ADDRESS | CITY | STATE | ZIP |
| CONTACT PERSON FOR APPLICANT | TELEPHONE ( ) | FAX ( ) | |
| APPLICANTS WASHINGTON STATE BUSINESS LICENSE NUMBER (UBI #) | APPLICANTS EMAIL ADDRESS | | |
| NAME OF IMMIGRATION ATTORNEY | TELEPHONE ( ) | FAX ( ) | |
| IMMIGRATION ATTORNEY ADDRESS | CITY | STATE | ZIP |
| NAME OF J-1 PHYSICIAN | WASHINGTON STATE MEDICAL LICENSE # | J-1 PHYSICIANS HOME COUNTRY | J-1 PHYSICIANS DATE OF BIRTH |
| J-1 PHYSICIAN COMPLETE PRACTICE LOCATION STREET ADDRESS | CITY | STATE | ZIP |
| GEOGRAPHIC LOCATION TO BE SERVED BY THE PHYSICIAN | CENSUS TRACT OR BLOCK NUMBERING AREA | FIPS COUNTY CODE | |
| ADDITIONAL SITE: COMPLETE PRACTICE LOCATION STREET ADDRESS | CITY | STATE | ZIP |
| ADDITIONAL GEOGRAPHIC LOCATION TO BE SERVED BY THE PHYSICIAN | CENSUS TRACT OR BLOCK NUMBERING AREA | FIPS COUNTY CODE | |
| ADDITIONAL POPULATION TO BE SERVED BY THE PHYSICIAN | | | |

1. Is the Physician complete with residency or fellowship training? ☐ Yes ☐ No If no, provide the date physician will complete training _____

*Documentation Required*: Submit a letter from the physician's residency or fellowship program that identifies the date the physician will complete their residency or fellowship program and confirms that the physician is in good standing with the program. The letter must be on the residency or fellowship programs letterhead and provide contact information for the signator; including name, title, relationship to the physician, address and telephone number.
OF NOTE: This information can be combined with the required letter in question #21.

2. Is the practice location in one of the following areas (check all that apply)?

☐ Health Professional Shortage Area (HPSA). Identifier #_____

☐ Population-Specific HPSA. Please specify the population_____Identifier #_____

☐ Whole County Medically Underserved Area (MUA). Identifier #_____

☐ Mental Health Professional Shortage Area (MHPSA) (for psychiatrists only). Identifier #_____

*Documentation Required:* Applicant must provide the HPSA, MUA, or MHPSA identifier number of the designation, and shall include the FIPS county code and census tract or block numbering area number or the nine-digit zip code of where the practice location is located. Primary care physicians must work full-time in a federally designated HPSA or MUA. Psychiatrists must work full-time in a MHPSA. Designations change periodically. Up-to-date information about HPSA designations can be found on the Internet at www.bphc.hrsa.dhhs.gov. HPSA, MUA, and MHPSA designation identifier numbers are assigned by the U.S. Department of Health and Human Services. FIPS County codes and census tract (tract/BNA code) or block numbering area numbers are assigned by the Bureau of Census and can be found on-line at www.ffiec.gov/geocode/default.htm by inputting address information of the practice location.

3. The health care facility is (check all that apply):

☐ For-Profit ☐ Non-Profit ☐ Government Organization ☐ Community Health Center

☐ Public Hospital District ☐ Other Publicly Funded Provider (specify)_____

☐ Other (specify)_____

4. Has the applicant notified all publicly funded providers in the HPSA or MUA designated areas of the intent to submit an application for a J-1 VISA Physician Waiver? ☐ Yes ☐ No

*Documentation Required.* Submit copies of all notification letters and certified mail receipts (signature required). WAC 246-562-060(8) requires all notification letters be sent at least 30 days prior to the date application will be submitted to the department.

5. Does the Health Care Facility agree to cooperate in providing the department with clarifying information, or information to verify the contents of this application, in any investigation of the applicant's financial status, or in any comment received from publicly funded providers? ☐ Yes ☐ No

*Documentation Required*. No additional documentation is required to accompany this application. The Health Care Facility will be notified by the department if additional information or assistance is needed.

6. Is the proposed practice location an existing facility or a new facility that will be operated by the Health Care Facility?
☐ Existing ☐ New

*Documentation Required*: For new facilities only - provide documentation of the legal, financial, and organizational structure necessary to provide a stable practice environment. A business plan must be submitted that supports this information. Written referral plans must be submitted that describes how patients using the new facility will be connected to other facilities if secondary or tertiary care is needed.

7. Has the health care facility been providing medical care for a minimum of twelve months prior to submitting this visa waiver application? ☐ Yes ☐ No

*Required Documentation*: No additional documentation is required. The health care facility which employs the Physician must have provided medical services in Washington for a period of twelve (12) months prior to submitting this application.

8. Please provide the percentage of total patient visits from the preceding 12 months that your health care facility provides to each of the following populations:

Medicaid_____% Subsidized Basic Health Plan Enrollees_____%

Uninsured_____% Medicare_____% Other Low-Income Patients_____%

*Documentation Required:* Submit a report or other documentation that supports the information provided above. Chapter 246-562 WAC requires that the health care facility must currently serve Medicare, Medicaid, low-income, and uninsured clients and the population of the federal designation. In addition, a minimum of 10% of your current total patient visits must serve Medicaid clients, and/or low-income clients. If this position will be filled in a new location/expansion of the existing facility, use the data from the existing facility.

9. How long have you been actively recruiting from among all qualified physicians that are graduates from U.S. medical schools for this specific position in this specific location?

☐ Less than 6 months ☐ 6 months to a year ☐ More than 1 year

Did you list with the Washington Recruitment Group? ☐ Yes ☐ No
If yes, how long _____

*Documentation Required*: Documentation must be provided which indicates your use of public or private recruitment efforts in a broad attempt to fill this position. An example of a public effort is to advertise the position in the Washington Recruitment Group's Opportunities List for six months. Examples of private efforts include the hiring of a private recruitment firm or advertising in a medical journal that has national distribution. The J-1 Visa Waiver Program should be used as a secondary recruitment effort and is not intended to replace a viable search for physicians that are graduates from U.S. medical schools.

10. What is the primary language of the underserved population served by the applicant facility?

_____

11. Does the health care facility have an existing sliding fee discount schedule? ☐ Yes ☐ No
If no, does the facility agree to implement a sliding fee discount schedule for the physician? ☐ Yes ☐ No

*Documentation Required*. Submit a copy of the facility sliding fee discount schedule. Sample schedules and notices are available from Office of Community and Rural Health.

12. Does the facility have a posted notice of the availability of a sliding fee discount schedule? ☐ Yes ☐ No

*Documentation Required*: Submit a copy of the posted notice of sliding fee discount availability. Notices must be in the primary language of the under served population.

13. Do you have a signed employment contract with the Physician? ☐ Yes ☐ No

*Documentation Required*: Two copies, with original signatures, of the contract must accompany this application with the contract cover sheet. The contract must contain all of the information/conditions outlined below:

| | | |
|---|---|---|
| Name and address of the health care facility, which will serve as the employer. | ☐ Yes | ☐ No |
| A complete description of the nature of the Physician's duties. | ☐ Yes | ☐ No |
| Identification of the wages to be paid to the Physician. | ☐ Yes | ☐ No |
| Description of the working conditions of the practice opportunity, including the facilities provided, malpractice insurance coverage, leave benefits, opportunities for continuing medical education, and other employee benefits | ☐ Yes | ☐ No |
| A total service requirement of not less than three years for primary care physicians or five years for specialist physicians from the start of employment with the same employer. | ☐ Yes | ☐ No |
| Statement that the Physician will provide not less than 40 hours per week providing clinical patient services in the designated shortage area. | ☐ Yes | ☐ No |

Statement of the specific federal shortage area that will be served by the Physician for the duration of the contract period. ☐ Yes ☐ No

Statement that the Physician will begin employment within 90 days from the date of the granted waiver ☐ Yes ☐ No

Statement that the Physician will provide physician services to Medicare or Medicaid recipients or other low-income patients and uninsured populations. ☐ Yes ☐ No

Statement that physician must see all patients, regardless of ability to pay, based on a sliding discount fee schedule implemented by facility. ☐ Yes ☐ No

Statement that the health care facility cannot prevent the Physician from providing clinical patient services in the designated shortage area after the term of employment ☐ Yes ☐ No

Statement by the physician that he or she agrees to meet the requirements set forth in Section 214 (L) of the Immigration and Nationality Act. ☐ Yes ☐ No

Nature of the primary care services to be provided full time by the physician.

☐ Family Practice ☐ General Internal Medicine ☐ Pediatrics
☐ Obstetrics and Gynecology ☐ Psychiatry ☐ Geriatric Medicine

☐ Specialist - Describe type of specialty service to be provided by the physician:

_____

**SPECIALISTS ONLY:**
What is the location and average distance to the nearest source of care comparable to the specialty of the J-1 physician?

_____

_____

Do you accept referrals from Community and/or Migrant Health Centers? ☐ Yes ☐ No

Please provide total number of patient encounters accepted from Community and Migrant Health Center referrals in last twelve months_____

*Documentation required:* The applicant must submit a copy of any referral agreements with Community and/or Migrant Health Center in service area and a letter from the Community and/or Migrant Health Center(s) located in service area documenting services.

14. Does the contract include any hand written notes/changes? ☐ Yes ☐ No

*Documentation Required*: All handwritten changes/notes/comments to the contract must be initialed and dated by both the Physician as well as the person authorized by the Health Care Facility to sign the contract. Each copy of the contract must contain original initials/dates.

15. Is the Health Care Facility offering the Physician, named in the visa waiver application, the same working conditions and salary that it would have otherwise offered to a physician who graduated from a U.S. medical school?
☐ Yes ☐ No

*Documentation Required*: The working conditions and salary must be outlined in the employment contract between the Health Care Facility and the Physician. In addition, a signed and approved by the U.S. Department of Labor, Labor Condition Application (Form ETA 9035) must accompany this visa waiver application.

16. Does the Health Care Facility agree to notify DOH **in writing** of the start date of employment? ☐Yes ☐ No

*Documentation Required*: No additional information is required to accompany this application. The Health Care Facility must notify DOH of the employment start date of the Physician named in this application. This start date will be used to determine the due dates for the six-month status reports.

17. Does the facility and J-1 physician agree to provide, every six months, status reports to the department for a period of three years for primary care physicians and five years for specialist, from the start date of employment? ☐ Yes ☐ No

*Documentation Required*. The six-month status reporting form is available from the DOH Office of Community and Rural Health or online at http://www.doh.wa.gov/hsqa/ocrh/r&r/semirpt.doc. The six-month status report forms must be completed and signed by both the Health Care Facility and the Physician and submitted to the Department of Health within **30 days following the end of each six month period** following the initial date of employment. If the Health Care Facility does not submit the required reports, DOH will find the Health Care Facility is in noncompliance, and may notify U.S. Department of State. Noncompliance may jeopardize the Physician's visa status and the Health Care Facility's future participation in the Physician Visa Waiver Program.

Proposed schedule for J-1 physician:

| Weekday | Work Hours | Location | Total Hours |
|---|---|---|---|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

Proposed call schedule: _____

_____

_____

18. Does the Health Care Facility agree to notify the Department of Health in the event of any change in the Physician's employment status, employment contract or a change in the ownership of the Health Care Facility if such occurs within the first three years for primary care applicants or the first five years for specialist applicants from the start date of employment? ☐ Yes ☐ No

*Documentation Required*: No additional documentation is required to accompany this application. Changes to the state or federal requirements of the employment contract must be submitted to the department for review and approval prior to implementation. The department will review and notify applicant of determination within 30 days of receipt of changes. Any changes in employment status may jeopardize the visa status of the J-1 Physician. Failure to notify DOH of any changes may result in notification of noncompliance to U.S. Department of State, as well as jeopardize the Health Care Facility's future participation in the Physician Visa Waiver Program.

19. Does the Physician have another application pending with any United States Government or agency or any other State Department of Health, to act on his/her behalf in any matter relating to a waiver of their two-year home country physical presence requirement? ☐ Yes ☐ No

*Documentation Required*: No additional documentation required. The federal government will not allow multiple J-1 waiver applications to be submitted simultaneously on behalf of the same Physician.

20. Is the Physician contractually obligated to return to a home country? ☐ Yes ☐ No

***Documentation Required***:

**If yes (to Question 20)**, then the Physician must obtain a "NO OBJECTION" letter from his/her home country, and it must be mailed directly to the U.S. Department of State. U.S. Department of State recommends the following language for the letter:
"Pursuant to Public Law 103-416, the government of_____
has no objection if (name and address of Physician) does not return to_____
to satisfy the two-year foreign residency requirement of section 212(e) of the Immigration and Nationality Act."

If this "NO OBJECTION" letter is required, the letter must be sent directly to U.S. Department of State and a copy of the letter included with this application.

**OR**

**If no (to Question 20)**, then a signed statement from the Physician, indicating that a "NO OBJECTION" letter is not required because the physician is not contractually obligated to return to the home country, must accompany this application.

21. Does the Physician have a Letter of Recommendation from his/her residency program? ☐ Yes ☐ No

*Documentation Required:* A minimum of one letter of recommendation must accompany this application. The letter, from the physician's residency program, must specifically address the physician's interpersonal and professional ability to effectively care for diverse and low-income people in the United States; describe the physician's ability to work well with supervisory and subordinate medical staff; and describe the physician's ability to adapt to the culture of United States health care facilities. The letter must be on the residency program's letterhead and provide contact information for the signator; including name, title, relationship to physician, address and telephone number.

22. Additional Documentation is required to process your application, and must accompany this application. Please verify that you have all the necessary documentation:

| | |
|---|---|
| • A current Curriculum Vitae for the Physician | ☐ Yes ☐ No |
| • All IAP-66 Forms (Certificate of Exchange visitor status) | ☐ Yes ☐ No |
| • G-28 from Attorney (optional) | ☐ Yes ☐ No |
| • U.S. Department of State Data Sheet | ☐ Yes ☐ No |
| • Proof of passage of all examinations required by INS | ☐ Yes ☐ No |
| • Copy of Medical degree (with certified translation) | ☐ Yes ☐ No |
| • Documentation of current status as a U.S. medical resident or completion of a U.S. medical residency program | ☐ Yes ☐ No |
| ▪ U.S. Department of Labor, Labor Conditions Application (Form ETA 9035) signed and approved by Department of Labor | ☐ Yes ☐ No |

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

Applicant
SIGNATURE _____ DATE _____

Physician
SIGNATURE _____ DATE _____

Submit two completed applications, **both copies** of the application form must contain **original signatures** and each application packet must include all required documentation.

Mailing Address:

Washington State Department of Health
Office of Community and Rural Health
Attention: J- l Visa Waiver Program
310 Israel Road SE
MS 7834
Tumwater WA 98501

All applications must be received by U.S. postal mail, commercial mail carrier, or be hand delivered. No faxes or other means of transmittal will be accepted.

**Do not use any staples in the assembly of this application or the required documentation.**

Applications will be accepted beginning October 1st of each year, until the maximum number of slots have been filled for that particular federal fiscal year. Each year 75% of total waiver slots will be allotted to primary care applicants and 25% of total waiver slots will be allotted to specialist applications. Applications received after all slots have been filled for the year will be returned to the applicant and may be resubmitted during the next application cycle.

The applicant will be notified in writing of the Department of Health's approval or denial to sponsor this application. If approved, DOH will add the necessary documentation that indicates our intention to act as a sponsor, and will forward ONE entire application packet to U.S. Department of State. You will be notified directly from U.S. Department of State of their approval/denial. Department of Health approval does not guarantee approval from the U.S. Department of State or the U.S. Immigration and Naturalization Services.

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